North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
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Richard J. Visingardi, Ph.D., Director

Memorandum

TO: Area Program Directors
CAP-MR/DD Providers
Direct Enrolled Residential Treatment Providers

FROM: Richard J. Visingardi, Ph.D.

RE: Revised Pages of the Service Records Manual

DATE: July 29, 2003

As a result of the re-codification (re-numbering) of the North Carolina Administrative Code, five pages in the revised Service Records Manual should be replaced with the attached the pages.

If you should have any questions, please feel free to contact the Regulatory Team at (919)420-7934.

CHAPTER IV: SCREENING/ASSESSMENT

SCREENINGS

There shall be documentation to demonstrate that an individual who is a consumer or who is not a consumer has been assessed for the purpose of determining the nature of the individual's *p*roblem(s) *a*nd need(s) for services and supports. A screening may be conducted face-to-face or by telephone, by a clinician or paraprofessional who has met the competency requirements within their scope of practice to conduct screenings.

An individual may have up to six screening contacts within the fiscal year before the individual is admitted as a consumer.

ASSESSMENT

1. Each individual who is accepted as a consumer must be assessed to appropriately identify need(s)/problem(s) of the consumer and when appropriate, needs for the family of the consumer. The assessment shall be completed within 24 hours.
2. The elements of the assessment process include, but are not limited to:
   a. reason for admission, which include need(s)/problem(s);
   b. strengths;
   c. preferences;
   d. evaluations, as appropriate, including but not limited to psychological, developmental, functional, social, physical, behavioral, economic, intellectual;
   e. mental status, as appropriate; and
   f. diagnosis (es).
3. Information gathered during the screening process or by other means such as discharge summaries, evaluations, etc. may be used to meet the assessment requirements. If other summaries, evaluations, etc. are used to meet these required elements, the summaries, evaluations, etc., shall be referenced and documentation to demonstrate that the information has been reviewed and is still current and accurate. A copy of the referenced document shall be filed in the consumer's record.
4. There may be instances when all elements in the assessment cannot be fully completed. When this occurs, information that is gathered at a later date shall be recorded on the assessment as an addendum with the entry dated and signed by the individual making the addendum.
5. The assessment shall be reviewed and updated as appropriate.

Note: Medicaid criteria for admission of persons under age 21 to a psychiatric hospital or a psychiatric unit of a general hospital can be located in 10A NCAC 22O .0112.

ENTRY MULTIDISCIPLINARY EVALUATION/ ASSESSMENT REQUIREMENTS FOR INFANTS AND TODDLERS

(CFR 303.322; CFR 303.166)

1. For infants and toddlers with or at risk for developmental disabilities, delays or atypical development, there shall be:
   a. an evaluation/assessment conducted within forty-five (45) calendar days of referral to the Infant-Toddler Program;
   b. an evaluation/assessment based on informed clinical opinion;

c. procedures developed and implemented to ensure participation by the consumer's family or the legally responsible person;

2. MR Personal Care (unless provided by a home care agency that is following their home care licensure rules);
3. In-Home Aide (unless provided by a home care agency that is following their home care licensure rules);
4. Interpreter Services;
5. Adult Day Health Care Services (for references to documentation requirements, see the Division of Aging web site at www.dhhs.state.nc.us/aging for North Carolina Adult Day Care and Day Health State Standards for Certification-10A NCAC 6S or contact them at 919-733-3983).
6. CAP-MR/DD Respite (Hourly, Community, Non-institutional, Nursing*;*
   Note: Institutional respite shall follow the State Mental Retardation Centers documentation requirements.
7. Non CAP-MR/DD Respite-The frequency of documentation for non CAP-MR/DD respite, is as follows:
   a. Hourly-per date of service; and
   b. Community-per duration of the event but not less than weekly

   Note: For additional respite documentation requirements, see Chapter X and Chapter XI in this manual.

Incidents or significant events in a consumer's life, which require additional activities or interventions, shall be documented.

Note: See Chapter IX for documentation requirements for Tangible Supports Services [Environmental accessibility Adaptations, Transportation, Waiver Equipment and Supplies, Personal Emergency Response System (PERS), Vehicle Adaptations, and Augmentative Communications Devices]

ADDITIONAL REQUIREMENTS

1. The completion of a service note or grid to reflect services provided shall be documented within 24 working hours. For reimbursement purposes, documentation shall be properly documented within sixty (60) calendar days from the date the service was provided to ensure the note or grid is properly documented. The area program/LME policy may be more restrictive than the allowed sixty (60) days.
2. If a service note or grid is documented after the required 24 working hours, it shall be considered a "late entry". The entry shall be noted as a "late entry" and at a minimum the date the documentation was made and the date for which the documentation should have been documented. For example, "Late entry made on 4/15/03 for 4/12/03."
3. In all cases, service notes shall be made more frequently than the above requirements when necessary to indicate significant changes in the consumer's status, needs or changes in the service plan.

2. Whenever corrections are necessary in the consumer's paper record, the following procedures shall be followed:
    a. corrections shall be made by the individual who recorded the entry;
    b. one single thin line shall be drawn through the error or inaccurate entry, making certain the original entry is still legible;
    c. record the corrected entry legibly above or near the original entry;
    d. record the date of the correction and initials of the recorder. An explanation as to the type of documentation error shall be included whenever the reason for the correction is unclear (e.g. "wrong consumer record", "transcription error");
    e. whenever omitted words cannot be inserted in the appropriate place above the record entry, the information should be made after the last entry in the record. Never "squeeze" additional information into the area where the entry should have been recorded.
3. Correcting fluid or tape shall not be used for correction of errors.

INCIDENT DOCUMENTATION

Service Record Documentation

1. Each service provider shall develop and implement a policy regarding the documentation of incidents. Incidents include but are not limited to: death of a consumer; injury to or caused by a consumer; property damage caused by a consumer; alleged abuse, neglect, or exploitation of a consumer; alleged criminal act by a consumer; alleged criminal act by others, having an impact on the consumer; leaving a designated site without supervision when it has been determined that the consumer needs ongoing supervision; violation of the rights of a consumer; accidental injury; adverse reaction to a medication; medication errors; emergency or unauthorized restraint or seclusion; violation of confidentiality of the consumer; suicidal threats and/or attempts.

Note: For consumers that receive CAP-MR/DD funding, the provider shall verbally report all incidents to the Lead Agency within 24 hours or less followed in writing within 72 hours.

Note: The policy shall comply with the Death Reporting rules as specified in 10A NCAC 26C .0300 and Client Rights rules as specified in Client Rights in Community Mental Health, Developmental Disabilities and Substance Abuse Service (APSM 95-2). Copies are available on the Division's web site, **www.dhhs.state.nc.us/mhddsas** or by contacting the Communications and Training Section at (919) 733-7011.

2. The policy shall include the requirement that incidents and other unusual circumstances shall be recorded in the service record including but not limited to:
    a. a description of the event;
    b. actions taken on behalf of the consumer; and
    c. the consumer's condition following the event.

Opinions, conclusions or personnel actions relative to an event shall not be included in the consumer's record.

required when it is not feasible because of an unanticipated discontinuation of a consumer's treatment.

Discharge Plan for Consumers Receiving Substance Abuse Services

Per Division publication *A*PSM 30-*1*, Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services, before discharging a consumer receiving substance abuse services, the facility shall complete a discharge plan and refer the consumer to the level of treatment or rehabilitation in accordance with the consumer needs.

MEDICATION-

(See 10A NCAC *27G .0209* in Division publication APSM 30-*1*, Rules for MH/DD/SA Facilities and Services)

1. Medications shall be self-administered by consumers only when authorized in writing by the consumer's physician.
2. A Medication Administration Record (MAR) of all drugs administered to each consumer shall be kept current. The MAR shall include:
   a. consumer's name;
   b. name, strength, and quantity of the drug;
   c. instructions for administering the drug;
   d. date and time the drug is administered; and
   e. name or initials of person administering the drug. If initials are used, the initials with the person's name shall be documented either on the MAR or a specified place in the record.
3. Outpatient Opioid Treatment requires documentation of review with the consumer regarding withdrawal from Methadone or other medications approved for use in narcotic addiction treatment at the initiation *of* treatment and annually thereafter. Documentation shall also include Methadone or other medications approved for use in narcotic addiction treatment given as take home dosages.
4. If the consumer receives psychotropic drugs, a pharmacist or physician shall review the consumer's drug regimen at least every six months. The findings of the review shall be recorded in the consumer's record along with corrective action, if applicable.
5. Whenever medication is prescribed by the area program/LME or provider's physician, there shall be documentation by the physician or designee to demonstrate that either oral or written medication education was provided to either the consumer or legally responsible person, if the ability of the consumer to understand is questionable. Documentation in the consumer's record shall include if the medication education was declined.
6. Drug administration error and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record.
7. A consumer's refusal of a drug shall be documented in the consumer's record.

OUTPATIENT SPECIALIZED THERAPY SERVICES

1. Speech therapy, PT and OT services require an ICD-9-CM diagnosis pertinent to the type of therapy provided.
2. A service order by a physician is required prior to the initiation of treatment. Treatment can proceed on the basis of a verbal order by the physician as long as the verbal order is documented in the consumer's record and the physician countersigns the order within 30 calendar days of the date of the verbal order.

CHAPTER XIII: PRIVACY AND SECURITY OF RECORDS

Policies and procedures as required by the Health Insurance Portability and Accountability Act (HIPAA). HIPAA regulations shall be developed.

SAFEGUARDS

Policies/procedures regarding the following shall be developed:

1. Ensures the safeguard of service records against loss, tampering, defacement, or use by unauthorized persons and ensures that service records are readily accessible to authorized users at all times.
2. If confidential information is stored in portable computers, a policy shall be developed which address the protection of such information. Recommended areas that the policy should address are as follows:
    a. The loan and use of portable computers;
    b. Purging confidential data from returned computer prior to assigning the same computer to the next user;
    c. Avoid maintaining confidential information on portable computers. Store confidential information on the facility network so the information can be backed up and maintained more securely. If net work storage is not possible, maintain the information on disk(s) and transport the disks separately from the computer case.
3. If the faxing of confidential information is allowed, policies/procedures to reflect how the information being faxed will be protected;
4. If email is used to communicate confidential information, a policy regarding how the confidential information will be secured and protected shall be developed.

If an electronic medical record is utilized, the following, but not limited to, policies shall be developed:

1. A policy, which defines the classifications of information (data sets) to which different users, may have access.
2. A policy, which specifies only identified users, has access to consumer information. The policy shall identify measures such as passwords, audit trails (a detailed record of who looked at, entered, or changed data, and when), etc. to help ensure only identified users have access to consumer information.

CONFIDENTIALITY

In addition to the HIPAA regulations, confidential information shall also be protected as follows:

1. Information in service records for individuals who receive mental health and developmental disabilities shall be disseminated in accordance with G.S. 122C-51 through G.S. 122C-56 and the Confidentiality Rules codified in 10A NCAC 26B (Division publication APSM 45-1).
2. Information in service records for those individuals who receive substance abuse services shall be disseminated in accordance with 42 C.F.R., Part 2-"Confidentiality of Alcohol and Drug Abuse Patient Records".